HIPAA Authorization Release Form

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information: (Check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases)including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify) _____
    _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reason.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____
  unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.)

_____
Printed Name of Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

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MINOR REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:_____
First *Middle* *Last*

DOB:_____ **Age:**_____ **Sex: Male Female** **SS#:**_____
Month/Day/Year *(Circle One)*

PARENT/GUARDIAN OR SPOUSE RESPONSIBLE FOR BILL

Name:_____ **SS #:**_____
First *Middle* *Last*

DOB:_____ **Relationship to Patient:**_____

Address:_____
Street (If P.O. Box, please also list street number) *Apt.* *City* *State* *Zip*

Mobile Phone: (____)_____ **Home Phone:** (____)_____

Employed By:_____ **Work Phone:** (____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins. Co. Name: _____

Policy Holder: _____

SS #: _____ **DOB:** _____

Group #: _____ **Policy #:** _____

SECONDARY INSURANCE

Ins. Co. Name: _____

Policy Holder: _____

SS #: _____ **DOB:** _____

Group #: _____ **Policy #:** _____

We need your authorization in order to file insurance, speak with or release written information to anyone about your condition. If there is anyone (such as spouse, parent, attorney, etc.) that will be calling on your behalf for any reason, please list them below.

_____

Name(s) of person(s) and/or insurance company(ies) authorized for release of information

The information I authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also know as Acquired Immune Deficiency Syndrome or AIDS. I further authorize the insurance company listed above to make payment directly to Orthopaedic Sports Medicine Center-Norman, P.C. for services regarding this illness or injury. I understand that I am financially responsible for payment of all charges. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a company of this medical practice's Notice of Privacy Practices.

I further acknowledge that I will be offered a copy of an amended Notice of Privacy Practices at each appointment.

Requested Restrictions_____

Parent/Guardian Signature:_____ **Date:** _____

Print Name:_____ **Relationship to Patient:**_____

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NEURO PATIENT MEDICAL FORM

PATIENT INFORMATION

Patient's Name: _____ **DOB:** _____

First *Last*

CURRENT MEDICAL HISTORY (check all of the medical symptoms that you are currently experiencing):

Constitutional:
- Fatigue ☐
- Fever ☐

HEENT:
- Hoarseness ☐
- Nose Bleed ☐

Cardiology:
- Chest Pain ☐
- Shortness of breath ☐
- Swelling of ankles ☐
- Palpitations ☐
- Fainting ☐

Neurology
- Blurry vision ☐
- Double vision ☐
- Loss of hearing ☐
- Ringing in ears ☐
- Numbness in face ☐
- Decreased ability to taste ☐
- Droopy face or eye ☐
- Difficulty speaking ☐
- Slurred speech ☐
- Headache ☐
- Dizziness ☐
- Seizures ☐

Respiratory
- Blood-tinged sputum ☐
- Wheezing ☐

Gastroenterology
- Abdominal pain ☐
- Black stools ☐
- Blood in stools ☐
- Heartburn ☐
- Nausea ☐

Hematology/Lymph
- Abnormal bleeding ☐

Musculoskeletal
- Joint swelling ☐
- Masses ☐
- Neck pain ☐
- Neck spasms ☐
- Cramps ☐
- Abnormal arm or leg feelings ☐
- Arm or leg weakness ☐
- Back pain ☐
- Weakness ☐
- Poor Coordination ☐
- Numbness ☐
- Tingling ☐
- Loss of sensation ☐
- Loss of muscle bulk ☐

Psychology:
- Depression ☐

Genito-Urinary
- Any burning of urination ☐
- Dark or discolored urine ☐
- Difficulty starting/ending urine stream ☐
- Poor control of bladder ☐
- Excessive thirst ☐
- Any type of sexual dysfunction ☐

Dermatology:
- Rash ☐

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____
First *Middle* *Last*

DOB: _____ **Age:** _____ **Sex:** **Male** **Female** **SS#:**_____-_____-_____
Month/Day/Year

Email:_____ **Cell Phone #:** (_____)_____

Address: _____
(If P.O. Box, please also list street number) City State Zip

Employer: _____ **Work Phone:** (_____)_____

PARENT/GUARDIAN OR SPOUSE RESPONSIBLE FOR BILL

Name: _____ **SS #:** _____-_____-_____ **DOB:** _____
First *Middle* *Last*

Relationship to Patient: _____ **Cell Phone#:** (_____)_____ **Alternate Phone:** (_____)_____

Address: _____
(If P.O. Box, please also list street number) *City* *State* *Zip*

Employer: _____ **Work Phone:** (_____)_____

IN CASE OF EMERGENCY

Emergency contact person outside your home: _____

Relationship to Patient: _____ **Phone:** (_____)_____

Address _____
Street *City* *State* *Zip*

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins. Co. Name: _____

Policy Holder: _____

SS #: _____ **DOB:** _____

Group #:_____ **Policy #:** _____

Policy Holder's Relationship to Patient: _____

SECONDARY INSURANCE

Ins. Co. Name: _____

Policy Holder: _____

SS #: _____ **DOB:** _____

Group #: _____ **Policy #:** _____

Policy Holder's Relationship to Patient: _____

The information I authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also know as Acquired Immune Deficiency Syndrome or AIDS. I further authorize the insurance company listed above to make payment directly to Orthopaedic Sports Medicine Center-Norman, P.C. for services regarding this illness or injury. I understand that I am financially responsible for payment of all charges. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices.

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Requested Restrictions_____

Print Name: _____ **Relationship to Patient:** _____

Patient's Signature (or parent/guardian if minor): _____ **Date:** _____

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PATIENT MEDICAL HISTORY FORM

PATIENT INFORMATION

Patient's Name: _____ **DOB:** _____

First *Last*

List All Medications that you are currently taking:

Medication	*Strength*	*Quantity*	*Frequency*

List any medication allergies: ☐ **N/A** _____

_____

List all past surgeries:

Surgery	*Year*

List all hospitalizations:

Reason for hospitalization	*Year*

Patient's Name: _____ **DOB:** _____

First *Last*

FAMILY HISTORY

Number of Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

Check the box for those medical histories that apply:

Member	Status	YOB	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer
Father	☐ Alive ☐ Deceased								
Mother	☐ Alive ☐ Deceased								
Sibling	☐ Alive ☐ Deceased								
Sibling	☐ Alive ☐ Deceased								
Sibling	☐ Alive ☐ Deceased								
Sibling	☐ Alive ☐ Deceased								
Sibling	☐ Alive ☐ Deceased								

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes Approximate number per day: _____

Are you pregnant? ☐ N/A ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you drink alcohol? ☐ Never ☐ Monthly ☐ Two to four times a month ☐ Two to Three times per month ☐ Four or more times per month

Do you exercise regularly? ☐ No ☐ Yes Times per week: _____

Have you traveled outside the U.S. in the past 10 years? ☐ No ☐ Yes

Have you ever used recreational drugs? ☐ No ☐ Yes

PAST MEDICAL HISTORY (check all medical conditions that apply):

Acid reflux	☐	Glaucoma	☐
Seasonal Allergies	☐	Gout	☐
Anemia	☐	Heart Disease	☐
Anxiety	☐	Hepatitis	☐
Asthma	☐	HIV	☐
Blood Clot	☐	High Blood Pressure	☐
Diabetes	☐	Seizures	☐
Emphysema	☐	Thyroid Disease	☐